CSHCN Services Program Physician/Dentist Assessment Form Instructions

Instrucciones para el Formulario de Evaluación del Médico / Dentista

(For Application to CSHCN Services Program / Parte de la solicitud al Programa de Servicios CSHCN)

Thank you for helping this family to apply for benefits from the Children with Special Health Care Needs (CSHCN) Services Program. The Physician/Dentist Assessment Form (PAF) is a key part of the application process. The PAF is a two-page form with a block that identifies the applicant, followed by six other short sections that you need to complete about the applicant. Section 7 is for information about you. Please fill in the applicant's identifying information and then go on to section 1.

1) DIAGNOSIS AND EVALUATION SERVICES (screening exam):

Please complete section 1 only if you need to do a workup or further examinations or tests to determine if the applicant meets the CSHCN Services Program's "medical certification definition" (see section 2).

If further examinations or tests are not needed, please check the "No" box. Do not leave this section blank. It will slow the application approval process.

Please note that whenever the CSHCN Services Program has a waiting list, the Program cannot pay for diagnosis and evaluation services for new applicants. To find out if the Program currently has a waiting list, call 1-800-252-8023.

2) MEDICAL CERTIFICATION DEFINITION:

Please pay particular attention to this section. It contains the Program's definition of a child with special health care needs. You must certify that the applicant does meet either definition A or B.

The primary diagnosis must be a chronic illness or disability that affects the applicant and meets the Program's definition. The form has spaces to add as many as three additional diagnoses.

Please ensure that the primary diagnosis is completed to the highest level of specificity (4 or 5 digits). Forms that are not filled out to their highest level will not be accepted by the CSHCN Services Program.

3) QUESTIONS FOR INITIAL APPLICATION TO THE CSHCN SERVICES PROGRAM:

Complete section 3 only if this is the first time the applicant has ever applied to the CSHCN Services Program.

4) DETERMINATION OF URGENT NEED FOR SERVICES:

This section is **very important,** especially when the CSHCN Services Program has a waiting list. Complete this section thoroughly. It has three parts.

Your answers to section 4 help the Program's physicians determine which children need health care services most urgently. This information is a factor in determining the order in which to remove clients from the waiting list whenever available funds make it possible to do so.

If you answer "yes" to 4a or 4b, you must provide an explanation. Use the space on the form or attach additional sheets if needed.

When answering 4a, please base your answer on what would happen if the applicant had no resources to pay for health care.

5) FUNCTIONAL NEEDS:

The Texas Legislature requires the CSHCN Services Program to collect this information. Please check **all** appropriate boxes.

6) SERVICES NEEDED:

Please talk with the family and then check the blocks for any and all services the applicant may require. This information will help the CSHCN Services Program plan for effective services now and in the future. It will not affect the applicant's eligibility for services.

7) PHYSICIAN/DENTIST DATA:

Section 7 requires the signature of the physician or dentist AND must be filled out completely. Phone numbers are especially important. In order to process the application, the doctor (M.D., D.O., D.D.S., or D.M.D.) must sign and date the form. It cannot be signed by a nurse or physician's assistant.

Thank you again for all you do to help the clients and families of the CSHCN Services Program!

CSHCN Services Program Physician/Dentist Assessment Form

Formulario de Evaluación del Médico / Dentista

(For Application to CSHCN Services Program / Parte de la solicitud al Programa de Servicios de CSHCN)

Please comp\lete and sign this form for the person applying for the Children with Special Health Care Needs (CSHCN) Services Program. The same form can be used for new and renewal applicants. If you need more copies or have questions, please refer to the instruction sheet or call 1-800-252-8023. Give the completed form to the parent or guardian, or send it to the applicant's local CSHCN Services Program office. *Only providers enrolled in the CSHCN Services Program may be reimbursed for diagnosis and evaluation services.*

PRIVACY NOTIFICATION

WITH FEW EXCEPTIONS, YOU HAVE THE RIGHT TO REQUEST AND BE INFORMED ABOUT INFORMATION THAT THE STATE OF TEXAS COLLECTS ABOUT YOU. YOU ARE ENTITLED TO RECEIVE AND REVIEW THE INFORMATION UPON REQUEST. YOU ALSO HAVE THE RIGHT TO ASK THE STATE AGENCY TO CORRECT ANY INFORMATION THAT IS DETERMINED TO BE INCORRECT. SEE HTTP://WWW.DSHS.STATE.TX.US FOR MORE INFORMATION ON PRIVACY NOTIFICATION. (REFERENCE: GOVERNMENT CODE, SECTION 552.021, 552.023, 559.003 AND 559.004)

NOTIFICACIÓN SOBRE LA PRIVACIDAD

CON POCAS EXCEPCIONES, USTED TIENE EL DERECHO A PEDIR Y SER INFORMADO SOBRE LA INFORMACIÓN QUE EL ESTADO DE TEXAS RECOPILA SOBRE USTED. USTED TIENE EL DERECHO A RECIBIR Y EXAMINAR LA INFORMACIÓN AL PEDIRLA. USTED TAMBIÉN TIENE EL DERECHO A PEDIR QUE LA AGENCIA ESTATAL CORRIJA CUALQUIER INFORMACIÓN QUE SE HA DETERMINADO SER INCORRECTA. DIRÍJASE A HTTP://WWW.DSHS.STATE.TX.US PARA MAYOR INFORMACIÓN SOBRE LA NOTIFICACIÓN SOBRE PRIVACIDAD. (REFERENCIA: CÓDIGO GUBERNAMENTAL, SECCIONES 552.021, 552.023, 559.003 Y 559.004)

THIS IS A TWO-PAGE FORM THAT REQUIRES THE SIGNATURE OF A MD, DO, DDS, OR DMD ON PAGE 2. FORMS WITHOUT THIS SIGNATURE ARE INCOMPLETE AND WILL BE RETURNED.

Applicant's Name (Last, First, Middle) _____ **Client No.** (if known) _____ **Date of Birth** (mm/dd/yyyy) _____

Address (Street, City, State, Zip) _____

Parent / Guardian Name _____ **Telephone** (_____) _____

1) DIAGNOSIS AND EVALUATION SERVICES (SCREENING EXAM):

Is this a request for coverage of services to determine whether the applicant has a chronic physical or developmental condition? If so, please indicate the appropriate V-Code and proceed to Physician/Dentist Data (Section 7). ☐ YES ☐ NO

If not, continue with rest of form. _____ *(V-code)*

2) MEDICAL CERTIFICATION DEFINITION AND DIAGNOSES:

The applicant must meet either definition A or B listed below:

A) A person younger than 21 years of age who has a chronic physical or developmental condition that:
- Will last or is expected to last for at least 12 months AND
- Results in, or if not treated, may result in limits to one or more major life activities AND
- Requires health and related services of a type or amount beyond those required by children generally AND
- Has a physical (body, bodily tissue, or organ) manifestation AND
- May exist with accompanying developmental, mental, behavioral, or emotional conditions BUT is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition.

B) A person of any age who has cystic fibrosis.

I CERTIFY THAT THE APPLICANT MEETS THE ABOVE DEFINITION. ☐ YES ☐ NO

PRIMARY DIAGNOSIS: *(condition must meet definition A or B above and, thus, must have a physical manifestation)*

ICD-9-CM Code *(required)*: _____ **Descriptor** *(required)*: _____

(ICD-9-CM codes *must be at the highest level of specificity* (4 or 5 digits). A 3-digit code is used only when there are no 4-or 5-digit codes within that category)

OTHER SECONDARY DIAGNOSES:

ICD-9-CM Code: _____ **Descriptor:** _____

ICD-9-CM Code: _____ **Descriptor:** _____

ICD-9-CM Code: _____ **Descriptor:** _____

3) QUESTIONS FOR INITIAL APPLICATION TO THE CSHCN SERVICES PROGRAM:

(if this is a renewal application, proceed to step 4)

Is applicant's condition a result of a traumatic injury or accident: ☐ YES ☐ NO

Date of trauma or accident (mm/dd/yyyy): _____

Date of discharge if hospitalized (mm/dd/yyyy): _____

Date of admission to rehab facility (mm/dd/yyyy): _____

Is applicant younger than one year of age: ☐ YES ☐ NO

Was the applicant born before 36 weeks gestation? ☐ YES ☐ NO

If yes, date of discharge after birth (mm/dd/yyyy): _____

Has the applicant spent 14 consecutive days out of the hospital? ☐ YES ☐ NO

Go to Page 2 / Vaya a la página 2

form is incomplete without both pages completed
el formulario está incompleto sin las dos páginas rellenadas

CSHCN Services Program Physician/Dentist Assessment Form *(page 2)*

Formulario de Evaluación del Médico / Dentista (página 2)

Applicant's Name: _____ *Client #:* _____ *DOB:* _____
(Last, First, Middle) *(if known)* *(mm/dd/yyyy)*

4) DETERMINATION OF URGENT NEED FOR SERVICES:

A) Would an inability to get healthcare services cause a permanent increase in disability, intense pain or suffering, or death? Please base your answer on what would happen if the applicant had no resources to pay for health care.

☐ *Yes. If yes, explanation required (use space provided or attach narrative):*

☐ *No. If no, continue with rest of form.*

B) Is the applicant actively planning to live in a nursing home, group home, or similar institution in the next six months?

☐ *Yes. If yes, explanation required (use space provided or attach narrative):*

☐ *No. If no, continue with rest of form.*

C) Please indicate any additional information related to the complexity or severity of applicant's condition or need for care that the CSHCN Services Program should know below or with attached narrative.

5) FUNCTIONAL NEEDS

Check appropriate blocks indicating the applicant's functional needs or limitations:

☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional

6) SERVICES NEEDED

Check the blocks for services the applicant may require.
(Data is for CSHCN Services Program planning purposes and does not affect eligibility.)

☐ bone marrow transplant
☐ case management
☐ dental services
☐ drugs
☐ durable medical equipment
☐ expendable medical supplies
☐ family support services
☐ growth hormone
☐ help with drug co-payments
☐ hemophilia blood factor products
☐ home health or nursing services
☐ inhaled tobramycin
☐ inpatient hospital
☐ Insurance Premium Payment Assistance
☐ mental health services
☐ outpatient services *(including PT, OT, & SLP)*
☐ physician services
☐ pulmozyme
☐ renal dialysis or transplant
☐ total parenteral nutrition
☐ transportation *(including meals and lodging)*
☐ vision services
☐ other: _____

7) PHYSICIAN / DENTIST DATA

_____ _____ _____ _____
Physician/Dentist's Name (type or print) *Provider Identifier #* *Tax ID #* *Specialty*

_____
Mailing Address (Street, City, State, and Zip Code)

( ) ( )

_____ _____ _____
Contact Person's Name (type or print) *Phone* *Fax*

_____ _____
PHYSICIAN/DENTIST SIGNATURE DATE
*(**MUST BE** signed by M.D., D.O., D.D.S., or D.M.D.)*

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